Washington State
DEPARTMENT OF
SOCIAL & HEALTH
SERVICES

## Medical Assistance Administration


# Medical Nutrition Therapy

**(Formerly known as Nutritional Counseling Services)**

**Billing Instructions**

**WAC 388-550-6300**

# Copyright Disclosure



# About this publication

**This publication supersedes all previous MAA Nutritional Counseling Services Billing Instructions.**

Related programs have their own billing instructions. Services and/or equipment related to any of the programs listed below must be billed using their specific billing instructions:

- Federally Qualified Health Centers
- Home Health Services
- Medical Nutrition
- Outpatient Hospital Services
- Physician-Related Services (RBRVS)
- Prescription Drug Program

Published by the Medical Assistance Administration
Washington State Department of Social and Health Services

Note: The effective date and publication date for any particular page of this document may be found at the bottom of the page.

**MAA changed the name of the Nutritional Counseling Services Program to Medical Nutrition Therapy.**

**Received too many billing instructions?**
**Too few?**
**Address incorrect?**

Please detach, fill out, and return the card located inside the back cover of this billing instruction. The information you provide will be used to update our records and provider information.

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# Important Contacts

A provider may use MAA's toll-free lines for questions regarding its programs. However, MAA's response is based solely on the information provided to MAA's representative at the time of inquiry, and in no way exempts a provider from following the laws and rules that govern MAA's programs. (WAC 388-502-0020(2)).

**Where do I call for information on becoming a DSHS provider, submitting a change of address or ownership, or to ask questions about the status of a provider application?**

**Provider Enrollment Unit**
1-866-545-0544

**Who do I contact about payments, denials, general questions regarding claims processing, or Healthy Options?**

**Provider Relations Unit**
1-800-562-6188

**Where do I send my claims?**

**Hard Copy Claims:**
Division of Program Support
PO Box 9247
Olympia WA 98507-9247

**Magnetic Tapes/Floppy Disks:**
Division of Program Support
Claims Control
PO Box 45560
Olympia, WA 98504-5560

**Who do I contact if I have questions regarding…**

**Private insurance or third party liability, other than Healthy Options?**

**Write/call:**
Division of Client Support
Coordination of Benefits Section
PO Box 45565
Olympia, WA 98504-5565
1-800-562-6136

**Electronic Billing?**

**Write/call:**
Electronic Billing Unit
PO Box 45512
Olympia, WA 98504-5512
1-360-725-1267

**How do I obtain copies of billing instructions or numbered memoranda?**

**Check out our web site at:**
http://maa.dshs.wa.gov

**Or write/call:**
Provider Relations Unit
PO Box 45562
Olympia WA 98504-5562
1-800-562-6188

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# Definitions

**This section defines terms and acronyms used throughout these billing instructions.**

**Certified Dietitian** – Certified dietitians in Washington State are:

- Dietitians or nutritionists who:
  - ✓ Have met the national educational standards of the American Dietetic Association;
  - ✓ Are designated as a Registered Dietitian; and
  - ✓ Have met additional specific health education requirements of the Washington State Department of Health, Division of Licensing;

☞ **Note:** Registered Dieticians licensed in the State of Oregon may be assigned an MAA-Certified Dietician provider number.

- Recognized by the medical profession as legitimate providers of nutrition care; and
- Healthcare professionals who translate scientific information about nutrition and diet into relevant terms for individuals.

**Client** – An applicant for, or recipient of, a DSHS medical care program.

**Code of Federal Regulations (CFR)** - A codification of the general and permanent rules published in the federal register by the executive departments and agencies of the federal government.

**Community Services Office(s) (CSO)** - An office of the department that administers social and health services at the community level. (WAC 388-500-0005)

**Core Provider Agreement** - A basic contract that the [DSHS] Medical Assistance Administration (MAA) holds with providers serving MAA clients. The provider agreement outlines and defines terms of participation with Medical Assistance.

**Department** - The state Department of Social and Health Services. (WAC 388-500-0005)

**Early and Periodic Screening, Diagnosis, and Treatment ( EPSDT)** - A program providing early and periodic screening, diagnosis and treatment to persons under 21 years of age who are eligible for Medicaid or the Children's Health Program. (WAC 388-500-0005)

**Explanation of Benefits (EOB)** - A coded message on the Medical Assistance Remittance and Status Report that gives detailed information about the claim associated with that report.

**Healthy Options -** The name of the Washington State Medical Assistance Administration's managed care program.

**Managed Care** - A prepaid comprehensive system of medical and health care delivery including preventive, primary, specialty, and ancillary health services. (WAC 388-538-050)

**Maximum Allowable -** The maximum dollar amount that a provider may be reimbursed by MAA for specific services, supplies, or equipment.

**Medicaid -** The state and federally-funded aid program that covers the Categorically Needy (CNP) and Medically Needy (MNP) programs.

**Medical Assistance Administration (MAA) -** The administration within DSHS authorized by the secretary to administer the acute care portion of the Title XIX Medicaid, Title XXI Children's Health Insurance Program (CHIP), and the state-funded medical care programs, with the exception of certain non-medical services for persons with chronic disabilities.

**Medical Identification card(s)** – Medical Identification cards are the forms DSHS uses to identify clients of medical programs. These cards are good only for the dates printed on them. Clients will receive a Medical Identification card in the mail each month they are eligible. These cards are also known as DSHS Medical ID cards and were formerly called medical coupons or MAID cards.

**Medically Necessary** - A term for describing [a] requested service which is reasonably calculated to prevent, diagnose, correct, cure, alleviate or prevent worsening of conditions in the client that endanger life, or cause suffering or pain, or result in an illness or infirmity, or threaten to cause or aggravate a handicap, or cause physical deformity or malfunction. There is no other equally effective, more conservative or substantially less costly course of treatment available or suitable for the client requesting the service. For the purpose of this section, "course of treatment" may include mere observation or, where appropriate, no treatment at all. (WAC 388-500-0005)

**Medical Nutrition**– The use of medical nutritionals (formulas) alone, or in combination with traditional food, when a client is unable to consume enough traditional food to meet their nutritional requirements. Medical nutritionals can be given orally or via feeding tubes.

**Medical Nutrition Therapy** - A face-to-face interaction between the certified dietitian and the client and/or client's guardian for the purpose of evaluating and making recommendations regarding the client's nutritional status.

**Medical Nutritionals** – The medical products used when providing Medical Nutrition.

**Nutritional Counseling** – See Medical Nutrition Therapy.

**Patient Identification Code (PIC)** - An alphanumeric code that is assigned to each MAA client consisting of:

- First and middle initials (a dash (-) must be entered if the middle initial is not indicated).
- Six-digit birthdate, consisting of numerals only (MMDDYY).
- First five letters of the last name (and spaces if the name is fewer than five letters).
- Alpha or numeric character (tiebreaker).

**Primary Care Case Management (PCCM)** The health care management activities of a provider that contracts with the department to provide primary health care services and to arrange and coordinate other preventive, specialty, and ancillary health services (WAC 388-538-050)

**Primary Care Provider (PCP)** – A person licensed or certified under Title 18 RCW including, but not limited to, a physician and advanced registered nurse practitioner (ARNP), or a physician assistant who supervises, coordinates, and provides health services to a client or an enrollee, initiates referrals for specialist and ancillary care, and maintains the client's or enrollee's continuity of care. (WAC 388-538-050)

**Provider or Provider of Service -** An institution, agency, or person:

- Who has a signed agreement [Core Provider] with the department to furnish medical care, goods, and/or services to clients; and
- Is eligible to receive payment from the department. (WAC 388-500-0005)

**Remittance And Status Report (RA) -** A report produced by MAA's claims processing system (known as the Medicaid Management Information System or MMIS) that provides detailed information concerning submitted claims and other financial transactions.

**Revised Code of Washington (RCW) -** Washington State laws.

**Third Party** - Any entity that is or may be liable to pay all or part of the medical cost of care of a medical program client. (WAC 388-500-0005)

**Title XIX** - The portion of the Federal Social Security Act that authorizes grants to states for medical assistance programs. Title XIX is also called Medicaid. (WAC 388-500-0005)

**Usual and Customary Fee –** The rate that may be billed to the department for a certain service or equipment. This rate *may not exceed*:

- The usual and customary charge that you bill the general public for the same services; or
- If the general public is not served, the rate normally offered to other contractors for the same services.

**Washington Administrative Code (WAC) -** Codified rules of the state of Washington.

**Women, Infant, and Children (WIC) Program** - The United States Department of Agriculture Special Supplemental Nutrition Program for Women, Infants and Children (WIC) administered by the Department of Health. Direct client services are delivered by contracted local providers. WIC provides nutrition screening, nutrition education, breastfeeding promotion, health and social service referrals, and nutritious foods to pregnant, breastfeeding and postpartum women, infants, and children through the end of the month they turn 5 years of age. To be eligible, WIC clients must have:

- A nutrition-related health risk; and

- Income at or below 185% of the Federal Poverty Level (FPL) or be enrolled in Medicaid, Food Stamps, or Temporary Assistance for Needy Families (TANF) programs.

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# About the Program

## What is the purpose of the Medical Nutrition Therapy Program?

The purpose of the Medical Nutrition Therapy Program (formerly known as Nutritional Counseling Services) is to ensure that clients have access to, and providers are reimbursed for, outpatient Medical Nutrition Therapy when:

- Medically necessary;
- Provided by a certified dietitian with an MAA provider number; and
- Provided to MAA-eligible clients who are 20 years of age and younger with an EPSDT referral.

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# Client Eligibility

## Who is eligible?

Medical nutrition therapy is available to Medicaid-eligible clients who meet all of the following criteria:

- Referred by an EPSDT provider;
- 20 years of age and younger; and
- Present their current Medical Identification card with one of the following identifiers:

| Medical Program Identifier | Medical Program |
|---|---|
| **CNP** | Categorically Needy Program |
| **CNP**<br>**Emergency Medical Only** | Categorically Needy Program – Emergency Medical Only – *(only when the service is related to the emergent medical condition)* |
| **CNP**<br>**Children's Health** | Categorically Needy Program - Children's Health |
| **CNP**<br>**CHIP** | Categorically Needy Program - Children's Health Insurance Program |

## Are clients enrolled in a Healthy Options managed care plan eligible for medical nutrition therapy?

Healthy Options managed care plans cover medical nutrition therapy when the client's Primary Care Provider (PCP) determines that medical nutrition therapy is medically necessary and writes a referral. The certified dietitian needs to be contracted with the Healthy Options plan and follow the plan's procedures for authorizations, referrals, and reimbursement.

☞ **Note:** Send all claims for services covered under the client's managed care plan to that plan for payment. To prevent billing denials, please check the client's Medical Identification card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCP and/or managed care plan.

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# Provider Requirements

## Which provider types may be reimbursed for medical nutrition therapy provided by a certified dietitian?

MAA reimburses the following provider types when medical nutrition therapy is provided by certified dietitians to MAA-eligible clients following provider types:

- Advanced Registered Nurse Practitioners (ARNP);
- Certified dietitians;
- Durable Medical Equipment (DME)
- Health Departments;
- Outpatient Hospitals; and
- Physicians.

☞ **Note:** When billing MAA, the certified dietitian's provider number must be entered in field #33 (PIN) on the HCFA-1500 claim form or in form locator #82 (Attending Physician's I.D.) on the UB-92 claim form.

☞ **Note:** Both Medical Nutrition Therapy and nondietitian professional services will not be paid when billed on the same claim form.

**For example:** Both services will not be reimbursed when billing for a physician office call and a medical nutrition therapy visit on the same claim. These services must be billed on separate claims.

## When may providers bill MAA for medical nutrition therapy provided in WIC program locations?

Providers may bill MAA for medical nutrition therapy provided in WIC program locations when the medical nutrition therapy is:

- Provided by a certified dietitian who has an MAA provider number; and
- Not a WIC service, therefore is not documented or funded as a WIC service.

# Who can refer a client for medical nutrition therapy?

EPSDT providers may refer a client to a certified dietitian for medical nutrition therapy if there is a medical need for nutritional services. Information concerning the medical need and the referral must be documented in the client's chart.

# What are the responsibilities of the certified dietitian regarding the referral?

The certified dietitian must:

- Obtain all medical information necessary to do a comprehensive nutritional assessment; and
- Keep the primary medical care provider apprised of the assessment, prognosis, and progress of the client.

**Note:** When billing MAA, the referring provider's name must be entered in field 17 and the MAA provider number in field 17a on the HCFA-1500 claim form or in form locator #83 on the UB-92 claim form.

# What are the appropriate conditions for referral?

MAA covers medical nutrition therapy when ***medically necessary***. Medical conditions that can be referred to a certified dietitian include, but are not limited to, the following:

**Inadequate or Excessive Growth** - e.g., failure to thrive, undesired weight loss, underweight, major change in weight-to-height percentile.

**Inadequate Dietary Intake** - e.g., formula intolerance, food allergy, limited variety of foods, limited food resources, poor appetite.

**Infant Feeding Problems** - e.g., poor suck/swallow, breast-feeding difficulties, lack of developmental feeding progress, inappropriate kinds or amounts of feeding offered, limited information and/or skills of caregiver.

**Chronic Disease Requiring Nutritional Intervention** - e.g., congenital heart disease, pulmonary disease, renal disease, cystic fibrosis, metabolic disorder, gastrointestinal disease.

**Medical Condition Requiring Nutritional Intervention** - e.g., iron-deficiency anemia, familial hyperlipidemia, pregnancy.

**Developmental Disability** – e.g., increasing the risk of altered energy and nutrient needs, oral-motor or behavioral feeding difficulties, medication-nutrient interaction, tube feedings.

**Psycho-Social Factors** - e.g., behaviors suggesting eating disorders. Clients with eating disorders should also be referred to the Division of Mental Health or its representatives (e.g., Regional Support Network) for treatment.

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**The Medical Nutrition Therapy Fee Schedule (previously found on pages D.1 – D.2) is now located in the appendix. To view or download the Fee Schedule, click Appendix.**

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# Billing

☞ **Note:** MAA will not reimburse for medical nutrition therapy services when billed on the same claim as nondietitian professional services.

**For example:** Providers will not be reimbursed when billing for a physician office call and a medical nutrition therapy visit on the same claim. These services must be billed on separate claims.

## What is the time limit for billing? [Refer to WAC 388-502-0150]

MAA requires providers to submit an initial claim, be assigned an internal control number (ICN), and adjust all claims in a timely manner. MAA has two timeliness standards: 1) for initial claims; and 2) for resubmitted claims.

- **Initial Claims**

  ✓ MAA requires providers to obtain an ICN for an **initial claim** within 365 days from any of the following:

  - The date the provider furnishes the service to the eligible client;
  - The date a final fair hearing decision is entered that impacts the particular claim;
  - The date a court orders MAA to cover the services; or
  - The date DSHS certifies a client eligible under delayed[1] certification criteria.

[1] **Delayed Certification -** According to WAC 388-500-0005, delayed certification means department approval of a person's eligibility for a covered service made after the established application processing time limits. If, due to delayed certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

**Eligibility Established After Date of Service but Within the Same Month -** If the client becomes eligible for a covered service that has already been provided because the client applied to the department for medical services later in the same month the service was provided (and is made eligible from the first day of the month), **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for the service; and **must promptly refund** the total payment received from the client or anyone acting on the client's behalf and then bill MAA for the service.

- ✓ MAA may grant exceptions to the 365 day time limit for **initial claims** when billing delays are caused by either of the following:

  - ➢ DSHS certification of a client for a retroactive[2] period; or
  - ➢ The provider proves to MAA's satisfaction that there are other extenuating circumstances.

- **<u>Resubmitted Claims</u>**

  - ✓ Providers may **resubmit, modify, or adjust** any timely initial claim, <u>except</u> prescription drug claims, for a period of 36 months from the date of service. Prescription drug claims must be resubmitted, modified, or adjusted within 15 months from the date of service.

☞ **Note:** MAA does not accept any claim for resubmission, modification, or adjustment after the designated time periods listed above.

- The designated time periods do not apply to overpayments that the provider must refund to DSHS. After the designated time periods, a provider may not refund overpayments to MAA by claim adjustment. The provider must refund overpayments to MAA by a negotiable financial instrument, such as a bank check.

- The provider, or any agent of the provider, must not bill a client or a client's estate when:

  - ✓ The provider fails to meet these listed requirements; and
  - ✓ MAA does not pay the claim. **(See WAC 388-502-0160 for more information.)**

# What fee should I bill MAA for eligible clients?

Bill MAA your usual and customary fee**.**

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[2] **Retroactive Certification -** According to WAC 388-500-0005, retroactive period means the three calendar months before the month of application (month in which client applied). If, due to retroactive certification, the client becomes eligible for a covered service that has already been provided, **the provider must not bill**, demand, collect, or accept payment from the client or anyone acting on the client's behalf for any unpaid charges for the service; **and may refund** any payment already received from the client or anyone acting on the client's behalf, and after refunding the payment, the provider may bill MAA for the service.

# How do I bill for services provided to PCCM clients?

For clients who have chosen to obtain care with a Primary Care Case Manager (PCCM), the identifier in the HMO column will be "PCCM." The PCCM is responsible for coordination of care including the referral for medical nutrition therapy services. Please refer to the client's Medical ID card for the PCCM.

> ☞ **Note:** To prevent billing denials, please check the client's MAID card prior to scheduling services and at the time of service to make sure proper authorization or referral is obtained from the PCCM.

When billing for services provided to Primary Care Case Management (PCCM) clients:

- Enter the referring physician or PCCM name in field 17 on the HCFA-1500 claim form or form locator #83 (Other Physician's I.D.) on the UB-92 claim form; and
- Enter the seven-digit MAA provider number of the PCCM who referred the client for the service(s). If the client is enrolled with a PCCM and the PCCM referral number is not in field 17a on the HCFA-1500 claim form or form locator #83 (Other Physician's I.D.) on the UB-92 claim form when you bill MAA, the claim will be denied.
- All services should be billed to MAA.

> ☞ **Note:** Newborns of clients who are connected with a PCCM are fee-for-service until a PCCM has been chosen for the newborns.

# What records must be kept? [Refer to WAC 388-502-0020]

Enrolled providers must:

- Keep legible, accurate, and complete charts and records to justify the services provided to each client, including, but not limited to:

  - ✓ Patient's name and date of birth;
  - ✓ Dates of service(s);
  - ✓ Name and title of person performing the service, if other than the billing practitioner;
  - ✓ Chief complaint or reason for each visit;
  - ✓ Pertinent medical history;
  - ✓ Pertinent findings on examination;
  - ✓ Medications, equipment, and/or supplies prescribed or provided;
  - ✓ Description of treatment (when applicable);
  - ✓ Recommendations for additional treatments, procedures, or consultations;
  - ✓ X-rays, tests, and results;
  - ✓ Plan of treatment and/or care, and outcome; and
  - ✓ Specific claims and payments received for services.

- Assure charts are authenticated by the person who gave the order, provided the care, or performed the observation, examination, assessment, treatment or other service to which the entry pertains.

- **Make charts and records available to DSHS, its contractors, and the US Department of Health and Human Services, upon their request, for at least six years from the date of service or more if required by federal or state law or regulation.**

# What additional records must be kept when providing medical nutrition therapy?

Enrolled providers must keep a copy of:

- Documentation that the WIC program is unable to provide all or part of the medically necessary medical nutritionals (formula);
- The referral from the EPSDT provider;
- The comprehensive medical nutrition therapy evaluation;
- Any correspondence with the referring provider; and
- Information concerning the medical need and the referral must be documented in the client's file.

# What additional information should be included in the medical nutrition evaluation when clients are receiving medical nutritionals that are reimbursed by MAA?

Include the following information in the medical nutrition evaluation. The determination and documentation of:

- The appropriate pediatric modifier*; and
- Why an individual's nutritional requirements cannot be met by traditional foods alone.

* See the current edition of MAA's Medical Nutrition Billing Instructions for a list of criteria and modifiers.

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# How to Complete the HCFA-1500 Claim Form

The HCFA-1500 (U2) (12-90) (Health Insurance Claim Form) is a universal claim form used by many agencies nationwide; a number of the fields on the form do not apply when billing the Medical Assistance Administration (MAA). Some field titles may not reflect their usage for this claim type. The numbered boxes on the claim form are referred to as fields.

**Important!**

## General Guidelines:

- **Use only the original preprinted red and white HCFA-1500 claim forms** (version 12/90 or later, preferably on 20# paper). This form is designed specifically for optical character recognition (OCR) systems. The scanner cannot read black and white (copied, carbon, or laser-printer generated) HCFA-1500 claim forms.

  If you need preprinted red and white HCFA-1500 claim forms, **call 1-800-562-6188.**

- **Do not use red ink pens, highlighters, "post-it notes," or stickers** anywhere on the claim form or backup documentation. The red ink and/or highlighter will not be picked up in the scanning process. Vital data will not be recognized. Do not write or use stamps or stickers that say, "REBILL," "TRACER," or "SECOND SUBMISSION" on claim form.

- **Use standard typewritten fonts** that are 10 c.p.i (characters per inch).
  Do not mix character fonts on the same claim form. Do not use italics or script.

- **Use upper case** (capital letters) for all alpha characters.

- **Use black** printer ribbon, ink-jet, or laser printer cartridges. Make sure ink is not too light or faded.

- **Ensure all the claim information is entirely contained within the proper field** on the claim form and on the same horizontal plane. Misaligned data will delay processing and may even be missed.

- **Place only six detail lines on each claim form**. MAA does not accept "continued" claim forms. If more than six detail lines are needed, use additional claim forms.

- **Show the total amount for each claim form separately**. Do not indicate the entire total (for all claims) on the last claim form. **Total each claim form**.

**FIELD DESCRIPTION**

**1a.** **Insured's I.D. No.**: Enter the Medicaid Patient Identification Code (PIC), an alpha-numeric code assigned to each MAA client. This information is obtained from the client's current monthly Medical ID card, and consists of the client's:

a) First and middle initials (or a dash (-) if the middle initial is not indicated)
b) Six-digit birthdate, consisting of *numerals only*
c) First five letters of the last name
d) An alpha character (tie breaker)

*For example:*

- Mary C. Johnson's PIC looks like this: MC010667JOHNSB.
- John Lee's PIC needs two spaces to make up the last name, does not have a middle initial and looks like this: J-100257LEE B

Use the PIC code of either parent for a newborn if the baby has not yet been issued a PIC; write "Baby on parent's PIC" in field 19 on the claim in this case. When using a parent's PIC for babies who are twins, triplets, etc., identify each baby separately (i.e., twin *A*, twin *B*) using a ***separate claim form*** for each.

**2.** **Patient's Name**: Enter the last name, first name, and middle initial of the MAA client (the receiver of the services for which you are billing).

**3.** **Patient's Birthdate**: Completion of this field is recommended. List the birthdate and sex of the MAA client.

**4.** **Insured's Name (Last Name, First Name, Middle Initial)**: If the patient has health insurance through employment or another source (e.g., private supplementary insurance, Federal Health Insurance Benefits, CHAMPUS, or CHAMPVA), list the name of the insured here. Enter the name of the insured except when the insured and the patient are the same - then the word *Same* may be entered.

**5.** **Patient's Address**: Enter the address of the MAA client who has received the services you are billing for (the person whose name is in field 2.)

**7.** **Insured's Address**: Enter the *insured's* address *only* if it is different from the *MAA client's* address.

**9.** **Other Insured's Name**: Complete this portion if other insurance is available. Use only to indicate insurance other than DSHS. Enter the last name, first name, and middle initial of the insured.

**9a.** The other insured's policy or group number *and* their social security number.

**9b.** The other insured's date of birth.

**9c.** The employer's name or the school name.

**9d.** The insurance plan name or the program name.

**10.** **Is Patient's Condition Related To**: Required. Check *yes* or *no* to indicate whether employment, auto accident or other accident involvement applies to one or more of the services described in *field 24*. ***Indicate the name of the coverage source in field 10d*** (L&I, name of insurance company, etc.).

**11d.** **Is There Another Health Benefit Plan?:** Indicate *yes* or *no*. If yes, you should have completed fields **9a. - d.**

**17.** **Name of Referring Physician or Other Source**: Required. Enter the name of the EPSDT provider who referred the client for medical nutrition therapy services.

**17a.** **I.D. Number of Referring Physician**: Required. Fill in the seven-digit identification number of the EPSDT provider who referred the client for medical nutrition therapy. Use the ***unique*** *identification number* assigned by MAA to individual providers, *not* the billing number assigned to the clinic.

**19.** **Reserved for Local Use**: When applicable, enter indicator **B** to indicate *Baby on Parent's PIC.* Please specify twin A or B, triplet A, B, or C here.

**22.** **Medicaid Resubmission**: If this billing is being submitted beyond the 365-day billing time limit, enter an ICN number that verifies that your claim was originally submitted within the time limit. (The ICN number is the *claim number* listed on the *Remittance and Status Report*.)

**24A.** **Date(s) of Service:** Enter numerically the month, day, and year of service (e.g., September 04, 2001 = 090401). When billing for more than one date of service, each day must be billed on separate lines. **Bill must not exceed 1-month increment.**

**24B.** **Place of Service**: Use the appropriate code(s):

| **Code Number** | **To Be Used For** |
|---|---|
| 2 | Outpatient Hospital |
| 3 | Office |
| 4 | Home |

**24C.** **T.O.S. - Type of Service**: Enter a **3** for all services billed.

**24D.** **Procedures, Services or Supplies CPT/HCPCS**: Enter the appropriate procedure code from these billing instructions.

**24E.** **Diagnosis Code**: Enter the appropriate ICD-9-CM diagnosis code related to the service provided. There must be a diagnosis code on each line billed. Enter exactly as shown in ICD-9-CM.

**24F.** **$ Charges**: Enter your usual and customary fee. If billing for more than one unit, the charge shown must be for the total of the units.

**24G.** **Days or Units**:– Enter:

- 97802, not more than 8 units per year.
- 97803, not more than 4 units per day.
- 97804, not more than 2 units per day.

**26.** **Your Patient's Account No.**: This is any nine-digit alpha/numeric entry ***that you may use as your internal reference number***. *You* create this number. Once you have submitted this account number to MAA, it will show up on the Remittance and Status Report under the column headed "Medical Record Number." *(Note: you may want to consider using this number for separating various accounts associated with your office, such as the accounts in different branch offices.)*

**28.** **Total Charge**: Enter the sum of your charges.

**29.** **Amount Paid**: If you receive an insurance payment, show the amount here, and attach a copy of the insurance EOB. If payment is received from source(s) other than insurance, specify source in ***field 10d***.

**30.** **Balance Due**: Enter total charges, minus any amount(s) you have entered in field 29.

**33.** **Physician's, Supplier's Billing Name, Address, Zip Code and Phone #**: Enter the name and address of the provider, as recorded with the Department of Social and Health Services.

**P.I.N.**: Enter the seven-digit provider number of the certified dietitian who performed the counseling session.

**GRP#:** Enter the "pay to" provider number assigned by MAA.

**For example:** A certified dietitian, not in a private practice, performs the medical nutrition therapy session. Enter the certified dietitian's provider number under "P.I.N." and the physician's provider number with which the certified dietitian is on staff under Group.

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

# SAMPLE

Medical Nutrition

APPROVED OMB-0938-0008

PICA

## HEALTH INSURANCE CLAIM FORM

PICA

CARRIER

PATIENT AND INSURED INFORMATION

1. MEDICARE ☐ (Medicare #) MEDICAID ☒ (Medicaid #) CHAMPUS ☐ (Sponsor's SSN) CHAMPVA ☐ (VA File #) GROUP HEALTH PLAN ☐ (SSN or ID) FECA BLK LUNG ☐ (SSN) OTHER ☐ (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PJ090824LONG B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LONG, PETE J.

3. PATIENT'S BIRTH DATE MM DD YY: 09 08 24 SEX M ☒ F ☐

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 62 SOUTH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self ☐ Spouse ☐ Child ☐ Other ☐

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single ☐ Married ☐ Other ☐ Employed ☐ Full-Time Student ☐ Part-Time Student ☐

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES ☐ NO ☒

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M ☐ F ☐

b. AUTO ACCIDENT? YES ☐ NO ☒ PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES ☐ NO ☒

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES ☐ NO ☒ *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PHYSICIAN OR SUPPLIER INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE

20. OUTSIDE LAB? YES ☐ NO ☐ $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. L 5698 .
2. .
3. .
4. .

22. MEDICAID RESUBMISSION CODE ORIGINAL REF. NO.

23. PRIOR AUTHORIZATION NUMBER

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 04 | 15 | 00 | 04 | 15 | 00 | 4 | 9 | 0030B | 2H | 569.8 | 23020 | 210 | | | | |
| 2 04 | 15 | 00 | 04 | 15 | 00 | 4 | 9 | B4036 | | 569.8 | 27500 | 30 | | | | |
| 3 04 | 15 | 00 | 04 | 15 | 00 | 4 | 9 | E0776 | RR | 569.8 | 971 | 1 | | | | |
| 4 | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | |

25. FEDERAL TAX I.D. NUMBER SSN ☐ EIN ☐

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES ☐ NO ☐

28. $ TOTAL CHARGE: 51491

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 51491

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY 360-222-1122
123 8TH STREET
ANYTOWN WA 98500

PIN# GRP# 9045681

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

PLEASE DO NOT STAPLE IN THIS AREA

[redacted]

# SAMPLE

Medical Nutrition
Sample: Medicare/Medicaid Crossover

APPROVED OMB-0938-0008

## HEALTH INSURANCE CLAIM FORM

PICA

PICA

CARRIER

1. MEDICARE [ ] (Medicare #) MEDICAID [X] (Medicaid #) CHAMPUS [ ] (Sponsor's SSN) CHAMPVA [ ] (VA File #) GROUP HEALTH PLAN [ ] (SSN or ID) FECA BLK LUNG [ ] (SSN) OTHER [ ] (ID)

1a. INSURED'S I.D. NUMBER (FOR PROGRAM IN ITEM 1): PJ090824LONG B

2. PATIENT'S NAME (Last Name, First Name, Middle Initial): LONG, PETE J.

3. PATIENT'S BIRTH DATE MM DD YY: 09 08 24 SEX M [X] F [ ]

4. INSURED'S NAME (Last Name, First Name, Middle Initial):

5. PATIENT'S ADDRESS (No., Street): 62 SOUTH STREET

6. PATIENT RELATIONSHIP TO INSURED: Self [ ] Spouse [ ] Child [ ] Other [ ]

7. INSURED'S ADDRESS (No., Street):

CITY: ANYTOWN STATE: WA

8. PATIENT STATUS: Single [ ] Married [ ] Other [ ] Employed [ ] Full-Time Student [ ] Part-Time Student [ ]

CITY: STATE:

ZIP CODE: 98000 TELEPHONE (Include Area Code): ( )

ZIP CODE: TELEPHONE (INCLUDE AREA CODE): ( )

9. OTHER INSURED'S NAME (Last Name, First Name, Middle Initial):

10. IS PATIENT'S CONDITION RELATED TO:

11. INSURED'S POLICY GROUP OR FECA NUMBER:

a. OTHER INSURED'S POLICY OR GROUP NUMBER:

a. EMPLOYMENT? (CURRENT OR PREVIOUS) YES [ ] NO [X]

a. INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. OTHER INSURED'S DATE OF BIRTH MM DD YY: SEX M [ ] F [ ]

b. AUTO ACCIDENT? YES [ ] NO [X] PLACE (State):

b. EMPLOYER'S NAME OR SCHOOL NAME:

c. EMPLOYER'S NAME OR SCHOOL NAME:

c. OTHER ACCIDENT? YES [ ] NO [X]

c. INSURANCE PLAN NAME OR PROGRAM NAME:

d. INSURANCE PLAN NAME OR PROGRAM NAME:

10d. RESERVED FOR LOCAL USE

d. IS THERE ANOTHER HEALTH BENEFIT PLAN? YES [ ] NO [X] *If yes*, return to and complete item 9 a-d.

**READ BACK OF FORM BEFORE COMPLETING & SIGNING THIS FORM.**

12. PATIENT'S OR AUTHORIZED PERSON'S SIGNATURE I authorize the release of any medical or other information necessary to process this claim. I also request payment of government benefits either to myself or to the party who accepts assignment below.

SIGNED _____ DATE _____

13. INSURED'S OR AUTHORIZED PERSON'S SIGNATURE I authorize payment of medical benefits to the undersigned physician or supplier for services described below.

SIGNED _____

PATIENT AND INSURED INFORMATION

14. DATE OF CURRENT: MM DD YY ILLNESS (First symptom) OR INJURY (Accident) OR PREGNANCY(LMP)

15. IF PATIENT HAS HAD SAME OR SIMILAR ILLNESS. GIVE FIRST DATE MM DD YY

16. DATES PATIENT UNABLE TO WORK IN CURRENT OCCUPATION MM DD YY FROM TO MM DD YY

17. NAME OF REFERRING PHYSICIAN OR OTHER SOURCE

17a. I.D. NUMBER OF REFERRING PHYSICIAN

18. HOSPITALIZATION DATES RELATED TO CURRENT SERVICES MM DD YY FROM TO MM DD YY

19. RESERVED FOR LOCAL USE: XO

20. OUTSIDE LAB? YES [ ] NO [ ] $ CHARGES

21. DIAGNOSIS OR NATURE OF ILLNESS OR INJURY. (RELATE ITEMS 1,2,3 OR 4 TO ITEM 24E BY LINE)

1. _____ . __ 3. _____ . __

2. _____ . __ 4. _____ . __

22. MEDICAID RESUBMISSION CODE: ORIGINAL REF. NO.:

23. PRIOR AUTHORIZATION NUMBER:

| 24. A DATE(S) OF SERVICE From MM | DD | YY | To MM | DD | YY | B Place of Service | C Type of Service | D PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances) CPT/HCPCS | MODIFIER | E DIAGNOSIS CODE | F $ CHARGES | G DAYS OR UNITS | H EPSDT Family Plan | I EMG | J COB | K RESERVED FOR LOCAL USE |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1 | 04 | 01 | 00 | 04 | 30 | 00 | 4 | 9 | B4150 | 40.00 | 596.8 | 23020 | 210 | | | | 200.00 |
| 2 | 04 | 01 | 00 | 04 | 30 | 00 | 4 | 9 | B4036 | 5100 | 596.8 | 27500 | 30 | | | | 255.00 |
| 3 | 04 | 01 | 00 | 04 | 30 | 00 | 4 | 9 | B9000 | RR 1.94 | 596.8 | 971 | 1 | | | | 9.71 |
| 4 | | | | | | | | | | | | | | | | | |
| 5 | | | | | | | | | | | | | | | | | |
| 6 | | | | | | | | | | | | | | | | | |

PHYSICIAN OR SUPPLIER INFORMATION

25. FEDERAL TAX I.D. NUMBER SSN [ ] EIN [ ]

26. PATIENT'S ACCOUNT NO.

27. ACCEPT ASSIGNMENT? (For govt. claims, see back) YES [ ] NO [ ]

28. $ TOTAL CHARGE: 51491

29. $ AMOUNT PAID:

30. $ BALANCE DUE: 37177

31. SIGNATURE OF PHYSICIAN OR SUPPLIER INCLUDING DEGREES OR CREDENTIALS (I certify that the statements on the reverse apply to this bill and are made a part thereof.)

SIGNED DATE

32. NAME AND ADDRESS OF FACILITY WHERE SERVICES WERE RENDERED (If other than home or office)

33. PHYSICIAN'S, SUPPLIER'S BILLING NAME, ADDRESS, ZIP CODE & PHONE #

UPTOWN MEDICAL SUPPLY 360-222-1122
123 8TH STREET
ANYTOWN WA 98500

PIN# GRP# 9045681

(APPROVED BY AMA COUNCIL ON MEDICAL SERVICE 8/88) ***PLEASE PRINT OR TYPE*** FORM HCFA-1500 (12-90), FORM RRB-1500, FORM OWCP-1500

# How to Complete the UB-92 Claim Form

## General Guidelines:

Only form locators that pertain to billing MAA are addressed below.

**When submitting more than one page of the UB-92, be sure to fully complete the first page. Only the *detail lines* are picked up from the second page. Please clearly indicate Page 1 of 2, Page 2 of 2, etc., in the *Remarks* section (*form locator 84*).**

**When billing electronically, indicate claim type "M" for Outpatient.**

***FORM LOCATOR NAME AND INSTRUCTIONS FOR COMPLETION***:

**1.** **Provider Name, Address & Telephone Number** - Enter the provider name, address, and telephone number as filed with the MAA Division of Program Support (DPS).

**3.** **Patient Control No.** - This is a twenty-digit alphanumeric entry **that you may use as your internal reference number**. You create this number. Once you have submitted this account number to MAA, it will appear on the Remittance and Status Report under the column titled *Patient Account Number*.

**4.** **Type of Bill** – Enter 131.

**6.** **Statement Covers Period** - Enter the beginning and ending dates of service for the period covered by this bill.

**12.** **Patient Name** - Enter the client's last name, first name, and middle initial as shown on the client's Medical Identification card.

**13.** **Patient's Address** - Enter the client's address.

**14.** **Patient's Birthdate** - Enter the client's birth date.

**15.** **Patient Sex** – Enter M for Male or F for female.

**17.** **Admit date** – Enter client's date of admittance.

**18.** **Admit hour** – Enter the client's hour of admittance.

**21.** **Discharge hour** – Enter the client's hour of discharge.

**42.** **Revenue Code** - Enter *001* for total charges on line 23 of this form locator on the final page.

**43.** **Revenue or Procedure Description** - Enter a narrative description of the related revenue or procedure codes included on this bill. Abbreviations may be used. Enter the description *total charges* on line 23 of this form locator on the final page.

**44.** **CPT/Rates** - Enter the appropriate CPT procedure code as listed in this billing instruction.

**46.** **Units of Service** – Enter:

- 97802, not more than 8 units per year.
- 97803, not more than 4 units per day.
- 97804, not more than 2 units per day.

**47.** **Total Charges** - Enter charges pertaining to the related procedure code(s). Enter the total of this column as the last detail on line 23 of this form locator on the last page.

**48.** **Noncovered** – Enter any noncovered charges pertaining to detail revenue or procedure codes here. (MAA will *categorically deny* these services.) Enter the total of this column as the last detail on line 23 of this form locator on the last page.

**50.** **Payer Identification: A/B/C** - Enter if health insurance benefits are available.

50A: Enter *Medicaid*.
50B: Enter the name of other insurance.
50C: Enter the name of other insurance.

**51.** **Provider Number** - Enter the hospital provider number issued to you by DPS. This is the seven-digit provider number beginning with a *3* that appears on your Remittance and Status Report.

**54.** **Prior Payments: A/B/C** - Enter the amount due or received from other insurance.

**55.** **Estimated Amount Due: A/B/C** - The amount estimated by the hospital to be due from the indicated payer (estimated responsibility less prior payments).

**58.** **Insured's Name: A/B/C** - If other insurance benefits are available and coverage is under another name, enter the insured's name.

**59.** **Patient's Relationship to Insured A/B/C** – Enter one of the following two-digit codes indicating the relationship of the patient to the identified insured:

| Code | Description |
|---|---|
| 01 = | Patient is insured |
| 02 = | Spouse |
| 03 = | Natural child/insured has financial responsibility |
| 04 = | Natural child/insured does not have financial responsibility |
| 05 = | Step child |
| 06 = | Foster child |
| 07 = | Ward of court/patient ward of insured |
| 08 = | Employee/patient employed by insured |
| 09 = | Unknown |
| 10 = | Handicapped dependent |
| 11 = | Organ donor |
| 12 = | Cadaver donor |
| 13 = | Grandchild |
| 14 = | Niece/nephew |

| Code | Description |
|---|---|
| 15 = | Injured plaintiff/patient claiming insurance as result of injury covered by insured |
| 16 = | Sponsored dependent |
| 17 = | Minor dependent of minor dependent |
| 18 = | Parent |
| 19 = | Grandparent |

**60.** **Cert-SSN-HIC-ID NO.** - Enter the MAA Patient (client) Identification Code (PIC) -an alphanumeric code assigned to each MAA client - exactly as shown on the Medical ID card. This information is obtained from the client's current monthly Medical ID card and consists of the client's:

a. First and middle initials (or a dash [-] *must* be used if the middle initial is not available).
b. Six-digit birth date, consisting of *numerals only* (MMDDYY).
c. First five letters of the last name. If there are fewer than five letters in the last name, leave spaces for the remainder before adding the tie breaker.
d. An alpha or numeric character (tiebreaker).

**61.** **Insurance Group Name** - If other insurance benefits are available, enter the name of the group or the plan through which insurance is provided to the insured.

**62.** **Insurance Group Number** - If other insurance benefits are available, enter any identification number that identifies the group through which the individual is covered.

**63.** **Treatment Authorization Code** - A number which designates the treatment covered by this bill has been authorized by the payer.

**65.** **Employer Name** - If other insurance benefits are available, enter the name of the employer that *might provide* or *does provide* health care coverage insurance for the individual.

**67.** **Principal Diagnosis Code** - Enter the appropriate ICD-9-CM diagnosis code related to the service provided. Enter exactly as shown in ICD-9-CM.

**68-75.** **Other Diagnosis Codes** - Enter additional ICD-9-CM diagnosis codes indicating any other conditions.

**82.** **Attending Physician I.D.** – Required. Enter the seven-digit provider number of the certified dietitian who performed the counseling session.

**83.** **Other Physician I.D. -** Fill in the name and seven-digit identification number of the EPSDT provider who referred the client for medical nutrition therapy. Use the ***unique*** *identification number* assigned by MAA to individual providers, *not* the billing number assigned to the clinic.

**84.** **Remarks** - Enter any information applicable to this stay that is not already indicated on the claim form. **For example:** Baby on Parent's PIC.

APPROVED OMB NO. 0938-0...

| 2 | | 3 PATIENT CONTROL NO. 9003762889 | 4 TYPE OF BILL 131 |
|---|---|---|---|
| 5 FED. TAX NO. | 6 STATEMENT COVERS PERIOD FROM 090101 THROUGH 090101 | 7 COV D. / 8 N-C D. / 9 C-I D. / 10 L-R D. / 11 | |

| 12 PATIENT NAME | 13 PATIENT ADDRESS |
|---|---|
| SMITH, JACOB J | 725 WALNUT GROVE, ANYTOWN, WA 98000 |

| 14 BIRTHDATE | 15 SEX | 16 MS | ADMISSION 17 DATE | 18 HR | 19 TYPE | 20 SRC | 21 D HR | 22 STAT | 23 MEDICAL RECORD NO. | CONDITION CODES 24 25 26 27 28 29 30 | 31 |
|---|---|---|---|---|---|---|---|---|---|---|---|
| 050191 | M | | 090101 | 13 | | | 15 | | | | |

| 32 OCCURRENCE CODE / DATE | 33 OCCURRENCE CODE / DATE | 34 OCCURRENCE CODE / DATE | 35 OCCURRENCE CODE / DATE | 36 OCCURRENCE SPAN CODE / FROM / THROUGH | 37 A B C |
|---|---|---|---|---|---|
| | | | | | |

| | 39 VALUE CODES CODE / AMOUNT | 40 VALUE CODES CODE / AMOUNT | 41 VALUE CODES CODE / AMOUNT |
|---|---|---|---|
| a | | | |
| b | | | |
| c | | | |
| d | | | |

| 42 REV. CD. | 43 DESCRIPTION | 44 HCPCS / RATES | 45 SERV. DATE | 46 SERV. UNITS | 47 TOTAL CHARGES | 48 NON-COVERED CHARGES | 49 |
|---|---|---|---|---|---|---|---|
| | NUTRITIONAL COUNSELING: INIT | 97802 | | 8 | 150.00 | | |
| 001 | TOTAL CHARGES | | | | 150.00 | | |

| 50 PAYER | 51 PROVIDER NO. | 52 REL INFO | 53 ASG BEN | 54 PRIOR PAYMENTS | 55 EST. AMOUNT DUE | 56 |
|---|---|---|---|---|---|---|
| MEDICAID | 3111111 | | | | 150.00 | |

57 DUE FROM PATIENT ▶

| 58 INSURED'S NAME | 59 P.REL | 60 CERT. - SSN - HIC. - ID NO. | 61 GROUP NAME | 62 INSURANCE GROUP NO. |
|---|---|---|---|---|
| | | JJ050195SMITHA | | |

| 63 TREATMENT AUTHORIZATION CODES | 64 ESC | 65 EMPLOYER NAME | 66 EMPLOYER LOCATION |
|---|---|---|---|
| | | | |

| 67 PRIN. DIAG. CD. | OTHER DIAG. CODES 68 / 69 / 70 / 71 / 72 / 73 / 74 / 75 CODE | 76 ADM. DIAG. CD. | 77 E-CODE | 78 |
|---|---|---|---|---|
| V65.3 | | | | |

| 79 P.C. | 80 PRINCIPAL PROCEDURE CODE / DATE | 81 OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | 82 ATTENDING PHYS. ID 820000 JULIA JONES |
|---|---|---|---|---|
| | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | OTHER PROCEDURE CODE / DATE | 83 OTHER PHYS. ID 1234567 |

JOHN NELSON EPSDT REFERRAL

84 REMARKS

OTHER PHYS. ID

85 PROVIDER REPRESENTATIVE X — 86 DATE

UB-92 HCFA-1450

I CERTIFY THE CERTIFICATIONS ON THE REVERSE APPLY TO THIS BILL AND ARE MADE A PART HEREOF.

OCR/Oriainal

# CORE PROVIDER AGREEMENT

The Department of Social and Health Services (the department) administers medical assistance and medical care programs for eligible clients. The department provides medical assistance or medical care to certain eligible clients by enrolling eligible providers of medical services.

The department reimburses enrolled eligible providers for covered medical services, equipment, and supplies they provide to eligible clients. To be eligible for enrollment, a provider must:

a. Complete the attached enrollment application;
b. Be an eligible provider and meet the conditions contained in WAC 388-502-0010;
c. Complete and sign a debarment form; and
d. Meet all the applicable state and/or federal licensure requirements to assure the department of his/her qualifications to perform services under this Agreement. This includes maintaining professional licensure in good standing without any stipulation in the provider's license.

A provider will be considered a participating provider once the provider completes the above requirements and signs this Agreement, the department issues a provider number, and the provider bills and accepts payment from the department.

As a participating provider in the medical assistance and medical care programs, hereafter known as Provider, the Provider agrees to the following:

1 **Governing Law and Venue.** This Agreement shall be governed by the laws of the State of Washington. In the event of a lawsuit involving this Agreement, venue shall be proper only in Thurston County, Washington.

The medical assistance and medical care programs are authorized and governed by Title XIX of the Social Security Act, Title XXI of the Social Security Act, Chapter IV of Title 42 of the Code of Federal Regulations, Chapter 74.09 of the Revised Code of Washington, and Title 388 of the Washington Administrative Code. The Provider is subject to and shall comply with all federal and state laws, rules, and regulations and all program policy provisions, including department numbered memoranda, billing instructions, and other associated written department issuances in effect at the time the service is rendered, which are incorporated into this Agreement by this reference.

2. **License.** The Provider shall be licensed, certified, or registered as required by State and/or Federal law. The Provider will notify the Department within seven (7) days of learning of any adverse action initiated against the license, certification, or registration of the Provider or any of its officers, agents, or employees.

3. **Billing and Payment.** The Provider agrees

a. To submit claims for services rendered to eligible clients, as identified by the department, in accordance with rules and billing instructions in effect at the time the service is rendered.
b. To accept as sole and complete remuneration the amount paid in accordance with the reimbursement rate for services covered under the program, except where payment by the client is authorized by applicable WAC. In no event shall the department be responsible, either directly or indirectly, to any subcontractor or any other party that may provide services.
c. To be held to all the terms of this Agreement even though a third party may be involved in billing claims to the department. It is a breach of this Agreement to discount client accounts (factor) to a third party biller or to pay a third party biller a percentage of the amount collected.

**Disclosure.** The Provider agrees to submit full and complete disclosure on the enrollment application the following:

a. Ownership and control information as required b' 42 Code Federal Regulations, parts 455.100 through 455.106;

b. Identity of any person who has ownership or control interest in the Provider, or is an agent or managing employee of the Provider who has been convicted of any felony and/or convicted of a criminal offense (felony or misdemeanor) relating to program crimes as required by 42 Code of Federal Regulations, part 455.106; and

c. Any denial, termination, or lack of professional liability coverage, or any change in professional liability coverage, including restrictions, modifications, or discontinuing coverage.

At any time during the course of this Agreement, the Provider agrees to notify the department of any material and/or substantial changes in information contained on the enrollment application given to the department by the Provider. This notification must be made in writing within thirty (30) days of the event triggering the reporting obligation. Material and/or substantial changes include, but are not limited to changes in:

a. Ownership;
b. Licensure;
c. Federal tax identification number;
d. Additions, deletions, or replacements in group membership; and
e. Any change in address or telephone number.

5. **Inspection; Maintenance of Records.** For six (6) years from the date of services, or longer if required specifically by law, the Provider shall:

a. Keep complete and accurate medical and fiscal records that fully justify and disclose the extent of the services or items furnished and claims submitted to the department.
b. The Provider shall make available upon request appropriate documentation, including client records, supporting material, and any information regarding payments claimed by the Provider, for review by the professional staff within the department or the Secretary of the U.S. Department of Health and Human Services. The Provider understands that failure to submit or failure to retain adequate documentation for services billed to the department may result in recovery of payments for medical services not adequately documented, and may result in the termination or suspension of the Provider from participation in the medical assistance and medical care programs.

6. **Audit or Investigation.** Audits or investigation may be conducted to determine compliance with the rules and regulations of the program. If an audit or investigation is initiated, the Provider shall retain all original records and **supportive** materials until the audit is completed and all issues are resolved even if the period of retention extends beyond the required 6-year period.

7. **Disputes.** Either party who has a dispute concerning this Agreement may request an administrative review hearing in accordance with applicable WAC.

8. **Termination.** The department shall deny, suspend, or terminate the Provider's enrollment for cause according to applicable WAC. Either the department or the Provider may terminate this agreement for convenience at any time upon 30 days written notification to the other. In the event that funding from state, federal, or other sources is withdrawn, reduced, or limited in any way, the department may terminate this Agreement. If this Agreement is terminated for any reason, the Department shall pay only for services authorized and provided through the date of termination.

9. **Advance Directives.** Hospitals, nursing facilities, providers of home health care and personal care services, hospices and HMO's must comply with the advance directive requirements as required by 42 Code of Federal **Regulations**, parts 489, subpart I, and 417.436

10. **Provider Not Employee Or Agent.** The Provider or its directors, officers, partners, employees and agents are not employees or agents of the department.

11. **Assignment.** The Provider may not assign this Agreement, or any rights or obligations contained in this Agreement, to a third party without the written consent of the department.

12. **Confidentiality.** The Provider may use Personal Information and other information gained by reason of this Agreement only for the purpose of this Agreement. The Provider shall not disclose, transfer, or sell any such information to any party, except as provided by law.

13. **Indemnification and Hold Harmless.** The Provider shall be responsible for and shall indemnify and hold the department harmless from all liability resulting from the acts or omissions of the Provider or any subcontractor.

14. **Severability.** The provisions of the Agreement are serverable. If any provision of the Agreement is held invalid by any court, that invalidity shall not affect the other provisions of this Agreement and the invalid provision shall be considered modified to conform to existing law.

15. **Certification.** This is to certify that the information provided in support of this Agreement is true and accurate and I completely understand that any falsification or concealment of a material fact may be prosecuted under Federal and State Laws. Willful misstatement of any material fact in the enrollment application may result in criminal prosecution. I acknowledge that this is being signed under the penalties of perjury and understand that the department is relying on the accuracy of the information I have presented. I agree to abide by the terms of this Agreement, including all applicable federal and state statutes, rules, and policies.

| SIGNATURE OF PROVIDER OR OWNER/MANAGER | TITLE | DATE |
|---|---|---|
| **If provider is a legal entity other than a person, the person signing the provider agreement on behalf of the Provider warrants that he/she has legal authority to bind Provider.** | | |
| FULL NAME (PRINTED) | PROVIDER SPECIALTY | |

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**Health & Recovery Services Administration (HRSA)**
**Medical Nutrition Therapy**
**Effective July 1, 2006**

| Code Status Indicator | Code | Mod | Maximum Allowable NFS | Maximum Allowable FS | PA? | Comments |
|---|---|---|---|---|---|---|
| R | 97802 | | $11.24 | $11.24 | | |
| R | 97803 | | $11.24 | $11.24 | | |
| R | 97804 | | $4.36 | $4.36 | | |

**Status Indictors**
D = Discontinued Code
N = New Code
P = Policy Change
R = Rate Update
# Not Covered in this program

**Health & Recovery Services Administration (HRSA)**
**Medical Nutrition Therapy**
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| Code Status Indicator | Code | Mod | Maximum Allowable NFS | Maximum Allowable FS | PA? | Comments |
|---|---|---|---|---|---|---|

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|---|---|---|---|---|---|---|